Primary care spending in Utah

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Utah Department of
Health & Human Services
Data, Systems & Evaluation

Utah Department of Health & Human Services
Health Care Information & Analysis Programs
http://healthcarestats.utah.gov/

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About this report

In late 2020, the Utah Department of Health and Human Services (DHHS) Health Care Statistics program (HCSP) produced the inaugural primary care spending within Utah report for the Utah Academy of Family Physicians (UAFP). Data from the Utah All Payer Claims Database (APCD) and Utah Healthcare Facility Database (HFD) for the years 2018-2019 were used to calculate the total amount of spending on primary health care services as a percentage of all health care expenditures. HSCP used the Maine Quality Forum's definition of primary care[1] and provided UAFP with the methodology used to perform the calculations, a description of the limitations, a breakout of primary care spending across payer types for each year, and a breakout by age cohorts and outcomes data for those years. In 2022, the Utah State Legislature approved House Bill 210 Primary Care Spending Amendments. The bill amended UCA §26B-8-504 (UCA §26-33a-106.1) and requires DHHS to publish a report on primary care spending in Utah every year.

This report used the same methodology to create an updated analysis of primary care spending included in the December 2022 report using data from 2021 and 2022.

About the data

Utah's All Payer Claims Database

The HCSP manages the APCD under authority granted to DHHS and the Utah Health Data Committee (HDC).[2] Licensed commercial health insurance carriers and pharmacy benefit managers, covering 2,500 or more Utah residents, are required to submit member eligibility, medical claims, dental claims, and pharmacy claims as well as a health care provider file by administrative rule.[3] The APCD also collects data from Utah Medicaid. The HCSP contracts with Milliman MedInsight for APCD data collection and processing. Milliman also enhances these data with risk adjusters, cost calculations, quality measures, and patient-provider attribution before it is delivered to the HCSP on a semi-annual basis.

[1] "Primary Care Spending in the state of Maine", page 14, https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf
[2] Utah Code 26B-8-504, https://le.utah.gov/xcode/Title26B/Chapter8/26B-8-S504.html
[3] Utah Administrative Rule R428-15, https://rules.utah.gov/publicat/code/r428/r428-015.htm

Utah Healthcare Facility Database

In 1992, the DHHS and the HDC developed a health care facility encounter database and began collecting inpatient discharge from all licensed hospitals in Utah and the Veterans Affairs Medical Center. Ambulatory surgery and emergency department encounter data collection was established in 1996. These data represent almost every hospitalization, emergency department visit, and ambulatory surgery in Utah for any given year, regardless of payer.

About the Health Care Statistics program

The Utah Department of Health and Human Services (DHHS) Health Care Statistics program (HCSP) implements the goals and directions of the Health Data Committee (HDC) and requirements outlined in U.C.A. § 26B, Chapter 8, Part 5. The program collects, analyzes, and disseminates health care data. These data help people understand cost, quality, access, and value in our health care system and allow users to identify opportunities for improvement.

The data sets under the purview of the program include:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**–annual customer satisfaction surveys related to health plan performance.
- **Healthcare Effectiveness Data and Information Set (HEDIS)**–annual quality measures relating to health plan performance.
- **Healthcare Facility Data (HFD)**–a collection of information about all inpatient, emergency room, and outpatient surgery/diagnostic procedures performed in the state.
- **All Payer Claims Data (APCD)**–a collection of data about health care paid for by third parties, including insurers, plan administrators, and dental and pharmacy benefits plans.

Utah Health Data Committee

The HDC was created by Utah Code 26B-1-413.[4] Members are appointed by the governor, confirmed by the senate, and represent various perspectives from industry and the community, including public health, purchasers, providers, payers, and patients. By law, members are required to have experience with health data.

[4] Utah Health Data Authority Act
https://le.utah.gov/xcode/Title26B/Chapter1/26B-1-S413.html?v=C26B-1-S413_2023050320230503

HDC mission statement (adopted 1994, amended 2020)

The mission of the HDC is to support health improvement initiatives through the collection, analysis, and public release of health care information. Through public/private collaboration, the HDC actively participates in the planning, development, implementation, and maintenance of a statewide health data reporting system, which provides accurate and independently validated information about health care in Utah. The HDC implements policies to transform data into objective baseline, trend, and performance measurement information, which is made available while preserving patient privacy and confidentiality.

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The HCSP would like to thank Matt Cottrell and Ryan Christenson for their analytic talent and their work on this report. Special thanks to Sydney Groesbeck (Utah Health Workforce Information Center lead analyst) for contributing the support functions necessary for this project to occur. Production of this statutory report would not be possible without the guidance, expertise, and efforts of those across the Data Systems and Evaluation division, including Kyle Lunt, Rick Little, Lori Savoie, and Mike Martin.

Methodology

Quality checks

It is vital to understand local insurance practices and trends to make sure the data accurately represents the population measured. This analysis used quality check procedures similar to those from previously published Utah primary care spending reports to identify payers and claims for inclusion and apply them to 2021 and 2022 primary care claims data. Detailed information on these processes is outlined in *Appendix C–Payer methodology*.

The claims data included in this report covers approximately 100% of the Children's Health Insurance Population (CHIP) population, 91% of the commercially insured population, 86% of the Utah Medicaid population, and 86% of the Medicare Part C population in Utah, which makes these results well-representative of the respective underlying populations.

Tabulating primary care spending

The methodology used to define and calculate primary care spending follows the methodology used by the Maine Quality Forum in their 2020 annual report[5] and previous Utah primary care reports. Additionally, the HCSP uses numerous data quality checks to validate the inclusion of complete and accurate data, detailed in *Appendix CPayer methodology*.

Specific providers, payers, and quality control parameters are identified annually and may vary from prior analysis due to changes in business practice, micro and macroeconomic trends, and other factors. For example, some providers and payers included in the past no longer conduct business in Utah, while others who have not previously provided services in Utah now do business in the state. Factors such as inflation, average per-member-per-month amounts allowed, and average per-member-per-month amounts paid out by specific payers may shift over time. As a result, inclusion criteria for billed services as part of primary care spending is determined by contextual comparison to

[5] "Primary Care Spending in the state of Maine", https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf

cohort payer types, population types, historical ranges, and current factors for comparable measures rather than static standards.

Provider specialty

Provider specialty was determined by linking to the National Provider and Payer Enumeration System (NPPES)[6] using NPI and extracting the "primary taxonomy code," which indicates a provider's primary specialty. Since claims in the Utah APCD have both billing and servicing provider NPIs, specialty was assigned using the following logic:

- *Is the listed servicing provider NPI on the claim tied to an individual?*
  - If yes, use the servicing provider primary taxonomy code from NPPES.
  - If not, proceed to the next step.
- *Is the listed billing provider NPI on the claim tied to an individual?*
  - If yes, use the billing provider primary taxonomy code from NPPES.
  - If not, proceed to the next step.
- *Is the listed servicing provider NPI on the claim tied to an organization?*
  - If yes, use the servicing provider primary taxonomy code from NPPES.
  - If not, proceed to the next step.
- *Is the listed billing provider NPI on the claim tied to an organization?*
  - If yes, use the billing provider primary taxonomy code from NPPES.
  - If not, assign to "unknown primary taxonomy".

Primary care services

Primary care services were measured in 2 different ways:

- all services performed by primary care providers (broad measure)
- specific primary care services performed by primary care providers (narrow measure)

[6] "National Plan and Provider Enumeration System (NPPES)", https://nppes.cms.hhs.gov/

Since providers with women's health specialties sometimes function as primary care providers, primary care services rendered by women's health specialists were included in the broad measure. The lists of provider specialty taxonomy codes and Healthcare Common Procedure Coding System (HCPCS) and Healthcare Common Procedure Coding System (CPT) procedure codes used to define primary care providers and primary care services are located in the appendix of this report.

Limitations

Various approaches have been proposed to calculate primary care spending. The results from this analysis may differ from other states' results due to variations in methods used.

The Utah All Payer Claims Database (APCD) is comprised of medical claims extracted from insurer and major government payer systems. Payments to health care providers outside of these claims systems are not represented in the database. Payments not in the database include health care paid by charities, with cash, by smaller governmental programs (such as Indian Health Services), and by other non-insurance arrangements. Furthermore, spending on primary care by insurers and government programs outside of the claims system (such as part of a value-based arrangement) are not included.

The APCD includes a large part of the covered Utah population. However, Medicare Part A and B and complete self-funded employer coverage are not in the APCD. Since approximately one third of Utah Medicare recipients use Medicare Part C in lieu of Part A and B, the results may not be completely representative of the broader Medicare population. Inclusion of self-funded employer data is limited to entities that opted to participate and contribute data to the APCD. As noted in the methodology section, the data used for this analysis covers more than half of the commercially insured population in Utah.

As outlined in the methodology section, provider specialty was determined by linking NPIs listed on the claims to NPPES. The accuracy of the listed provider specialty in NPPES was not verified. Because of this, some claims may have been erroneously classified.

Findings

Primary care spending in Utah by payer type

The tables below provide a breakdown of primary care spending in Utah for calendar years 2021 and 2022 by payer type and use both the narrow and broad measures for primary care spending. Across all payer types, CHIP represents the payer with the highest proportion of primary care spending for 2021 (11.9% and 17.8%, narrow and broad measures, respectively) and 2022 (9.5% and 13.3%, narrow and broad measures, respectively). The narrow and broad measures for commercial payers were 6.1% and 8.1% in 2021 and did not change significantly in 2022 (6.2% and 8.2%). In 2021, Medicaid narrow and broad measures were 3.7% and 5.9%, respectively, and 6.2% and 8.2% in 2022. Medicare Part C's percentage of primary care spending was 5.0% and 7.9% across narrow and broad measures in 2021 and 5.4% and 8.7% in 2022.

Among payer types between the two years observed in this report, only CHIP experienced a decrease in broad and narrow measures for primary care spending while all other payers experienced an increase. The largest decrease occurred with CHIP broad primary care spending (-4.5%) followed by CHIP narrow primary care spending (-2.4%). The 2 payer types whose primary care spending increased the most from 2021 to 2022 were Medicare (0.4% narrow, 0.8% broad) and Medicaid (0.4% narrow, 0.5% broad). When including all payers, narrow primary care spending was 5.3% in 2021 and increased to 5.5% in 2022; while broad primary care spending was 7.5% in 2021 and increased to 7.8% in 2022.

Table 1: Percentage of spending to primary care by payer type in 2021

Payer type	Narrow	Broad	Unclassified[7]
CHIP	11.9%	17.8%	0.0%
Commercial	6.1%	8.1%	1.0%
Medicaid	3.7%	5.9%	16.79%
Medicare Part C	5.0%	7.9%	0.4%
Combined	5.3%	7.5%	5.5%

Table 2: Percentage of spending to primary care by payer type in 2022

Payer type	Narrow	Broad	Unclassified[7]
CHIP	9.5%	13.3%	0.0%
Commercial	6.2%	8.2%	0.9%
Medicaid	4.1%	6.4%	20.1%
Medicare Part C	5.4%	8.7%	0.2%
Combined	5.5%	7.8%	6.0%

[7] The higher percentage of Unclassified spending is mainly because Medicaid uses the Primary Taxonomy Code Flag differently than other payers. This happens when the Primary Taxonomy Code Flag is empty. However, Medicaid (0200-Medicaid) stands out as it often has a filled Primary Taxonomy Code Flag, leading to more Unclassified spending. Despite this, we included Medicaid in the analysis due to its significant size, with 486,594 distinct members in 2021 and 545,694 in 2022. Comparatively, the second-largest payer, Select Health, had 179,415 distinct members in 2021 and 192,107 in 2022. If we exclude Medicaid from the analysis, Medicaid's Unclassified spending becomes 0%.

Primary care spending in Utah by age groups

The tables below illustrate primary care spending in Utah by age groups and use narrow and broad measures for primary care spending. Consistent with the higher rates of primary care spending for CHIP in the previous section, the age group with the highest proportion of primary care spending in Utah is for those in the 0-17 age group. Primary care spending for the 0-17 age group was 11.2% and 13.8% in 2021 across narrow and broad measures. In 2022 narrow spending was 11.4% and broad spending was 14.1%, which represents slight increases. The narrow and broad measures for the 18-24 age group remained the same, while all other age groups except for the unknown group experienced increases. The largest increases occurred in the 65-74 and 75-79 age groups. The 65-74 age group experienced an increase of 0.4% in narrow and 0.9% in broad measures while the 75-79 age group increased by 0.4% in narrow and 0.8% in broad measures.

Table 3: Percentage of spending to primary care by age in 2021

Age group	Narrow	Broad	Unclassified[8]
0-17	11.2%	13.8%	2.3%
18-24	4.8%	7.2%	12.2%
25-34	3.9%	6.1%	10.3%
35-44	4.1%	6.2%	7.5%
45-54	3.9%	5.7%	4.9%
55-64	3.3%	4.8%	3.2%
65-74	4.3%	6.8%	3.7%

[8]The higher percentage of Unclassified spending is mainly because Medicaid uses the Primary Taxonomy Code Flag differently than other payers. This happens when the Primary Taxonomy Code Flag is empty. However, Medicaid (0200-Medicaid) stands out as it often has a filled Primary Taxonomy Code Flag, leading to more Unclassified spending. Despite this, we included Medicaid in the analysis due to its significant size, with 486,594 distinct members in 2021 and 545,694 in 2022. Comparatively, the second-largest payer, Select Health, had 179,415 distinct members in 2021 and 192,107 in 2022. If we exclude Medicaid from the analysis, Medicaid's Unclassified spending becomes 0%.

Age group	Narrow	Broad	Unclassified[8]
75-79	4.3%	7.1%	2.7%
80-84	4.4%	7.3%	3.4%
85+	4.2%	7.5%	4.9%
Combined	5.3%	7.5%	5.5%
Unknown	1.5%	2.3%	30.5%

Table 4: Percentage of spending to primary care by age in 2022

Age group	Narrow	Broad	Unclassified[9]
0-17	11.4%	14.1%	2.4%
18-24	4.8%	7.2%	14.0%
25-34	4.0%	6.3%	11.8%
35-44	4.3%	6.4%	8.5%
45-54	4.0%	5.9%	5.6%
55-64	3.5%	5.2%	3.6%
65-74	4.7%	7.7%	3.6%
75-79	4.7%	7.9%	2.5%
80-84	4.7%	7.8%	2.9%
85+	4.5%	7.7%	4.0%
Combined	5.5%	7.8%	6.0%
Unknown	1.4%	2.2%	64.4%

[9] The higher percentage of Unclassified spending is mainly because Medicaid uses the Primary Taxonomy Code Flag differently than other payers. This happens when the Primary Taxonomy Code Flag is empty. However, Medicaid (0200-Medicaid) stands out as it often has a filled Primary Taxonomy Code Flag, leading to more Unclassified spending. Despite this, we included Medicaid in the analysis due to its significant size, with 486,594 distinct members in 2021 and 545,694 in 2022. Comparatively, the second-largest payer, Select Health, had 179,415 distinct members in 2021 and 192,107 in 2022. If we exclude Medicaid from the analysis, Medicaid's Unclassified spending becomes 0%.

Utah hospitalizations and emergency department visits

The table below provides counts of hospitalizations and emergency department visits from 2021 and 2022. While the count of emergency department visits increased from 2021 to 2022 by 8%, the count of hospitalizations decreased by 3%.

Table 5: Hospitalizations and emergency department visits, 2021 and 2022

Type	2021	2022
Total hospitalizations	289,454	280,275
Emergency department visits	786,648	850,906

Conclusion

In conclusion, this report used the Maine Quality Forum methodology, data quality checks, and other data validation measures to explore what percentage of Utah's total health care expenditures for 2021 and 2022 is attributed to primary care spending. The analysis demonstrates that primary care spending in Utah appears consistent with primary care spending found in other states, according to the most recent report from Maine.[10] Given that the Maine report is not inclusive of all states, it is uncertain how primary care spending in Utah compares at a national level.

[10] https://mhdo.maine.gov/_pdf/MQF%20Annual%20Primary%20Care%20Spending%20Report_%20year%204_230216.pdf

Appendix A–Primary care specialty taxonomy codes

Allopathic and osteopathic physicians
207Q00000X–family medicine physician
207R00000X–internal medicine physician
207RG0300X–geriatric medicine (internal medicine) physician
207V00000X–obstetrics and gynecology physician
207VG0400X–gynecology physician
208000000X–pediatrics physician
2083P0500X–preventive medicine/occupational environmental medicine physician
208D00000X–general practice physician

Ambulatory health care facilities
261QF0400X–federally-qualified health center (FQHC)
261QP2300X–primary care clinic/center
261QR1300X–rural health clinic/center

Nursing service providers
163W00000X–registered nurse

Other service providers
175F00000X–naturopath
175L00000X–homeopath

Physician assistants and advanced practice nursing providers
363A00000X–physician assistant
363AM0700X–medical physician assistant
363L00000X–nurse practitioner
363LA2200X–adult health nurse practitioner
363LF0000X–family nurse practitioner
363LP0200X–pediatric nurse practitioner
363LP2300X–primary care nurse practitioner
363LW0102X–women's health nurse practitioner

363LX0001X–obstetrics and gynecology nurse practitioner
364S00000X–clinical nurse specialist

Appendix B–Primary care services

Alcohol and drug rehabilitation/detoxification
99408, 99409

Consultation, evaluation, and preventive care
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99356, 99357, 99358, 99359, 99360, 99367, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99420, 99429, 99487, 99490, 99491, 99497, 99498, G0108, S0610, S0612, S0613

Diagnostic physical therapy
96110

Diagnostic procedures, male genital
G0102

HCPCS not classified
G8420, G8427, G8482, G8709, G8711, G8730, G8950, G9903, G9964, G9965, G9966, G9967

Laboratory–chemistry and hematology
G0103

Mammography
G0202

Microscopic examination (bacterial smear, culture, toxicology)
G0475, G0476

Non hospital-based care (home health care, hospice)
99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0151, G0249

Other diagnostic procedures, female organs
G0101, G0123

Other laboratory
G0472

Other non-OR therapeutic cardiovascular procedures
G0166

Other therapeutic procedures
96372, 96373, 96374

Pathology
G0145

Prophylactic vaccinations and inoculations
90281, 90287, 90288, 90291, 90296, 90371, 90375, 90376, 90384, 90385, 90386, 90389, 90393, 90396, 90399, 90460, 90461, 90465, 90466, 90467, 90468, 90471, 90472, 90473, 90474, 90476, 90477, 90581, 90585, 90586, 90587, 90620, 90621, 90625, 90630, 90632, 90633, 90634, 90636, 90644, 90645, 90646, 90647, 90648, 90649, 90650, 90651, 90653, 90654, 90655, 90656, 90657, 90658, 90659, 90660, 90661, 90662, 90663, 90664, 90665, 90666, 90667, 90668, 90669, 90670, 90672, 90673, 90674, 90675, 90676, 90680, 90681, 90682, 90685, 90686, 90687, 90688, 90689, 90691, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90712, 90713, 90714, 90715, 90716, 90717, 90718, 90719, 90720, 90721, 90723, 90725, 90727, 90732, 90733, 90734, 90735, 90736, 90738, 90739, 90740, 90743, 90744, 90746, 90747, 90748, 90749, 90750, 90756, G0008, G0009

Psychological and psychiatric evaluation and therapy
90785, 96160, 96161, 99354, 99355

Telehealth
98966, 98967, 98968, 98969, 99441, 99442, 99443, 99444, 99495, 99496

Appendix C–Payer methodology

All primary care spending for calendar years 2021 and 2022 was analyzed through a series of quality control guidelines. Payers that met minimum quality levels were included in the analysis, grouped by payer, payer type, age group, and service year. Payers who did not meet minimum quality levels were excluded from the analysis, with a few noted exceptions. Broad, narrow, and unclassified amounts and total amounts paid by grouping were aggregated. The number of claims, proportion of claims associated with procedure groupings, and distinct member counts were also calculated and used in tandem with other quality control reviews.

The following quality checks were used as a guideline to determine inclusion:

Per member per month (PMPM)
Are the payers' average PMPMs within expected ranges for the relevant line of business?

- Commercial PMPM between $205-$361
- Medicare between $170-$715
- Medicaid/CHIP between $151-$262

Financial field sums
Are the payers' financial field sums within expected ranges across claim types (inpatient, outpatient, and professional)?

- Share of spending on commercial inpatient claims between 19%-34%
- Share of spending on commercial outpatient claims between 28%-48%
- Share of spending on commercial professional claims between 29%-42%
- Share of spending on Medicaid and Medicare inpatient claims between 27%-46%[11]

[11] An exception was made to include a Medicaid plan with the share of spending on inpatient claims of approximately 48%.

- Share of spending on Medicaid and Medicare outpatient claims between 18%-33%[12]
- Share of spending on Medicaid and Medicare professional claims between 19%-34%.[13]

HCPCS/CPT codes

Do the payers' HCPCS/CPT code distributions follow expectations for completeness?

- 47%-76% of commercial HCPCS/CPT codes should start with 9
- 5%-27% of commercial HCPCS/CPT codes should start with 8
- 3%-8% of commercial HCPCS/CPT codes should start with 7
- 34%-73% of Medicaid HCPCS/CPT codes should start with 9
- 9%-17% of Medicaid HCPCS/CPT codes should start with 8
- 3%-9% of Medicaid HCPCS/CPT codes should start with 7
- 29%-52% of Medicare HCPCS/CPT codes should start with 9
- 13%-30% of Medicare HCPCS/CPT codes should start with 8
- 4%-10% of Medicare HCPCS/CPT codes should start with 7
- Fewer than 1% of all insurance types HCPCS/CPT codes should be missing

National provider identifiers (NPIs)

Are the payers' billing and servicing provider NPIs complete and valid?

- No more than 2% of the claims should have missing or invalid NPIs.[14]

[12] An exception was made to include 2 Medicaid plans with the share of spending on outpatient claims of approximately 10% and 12%.
[13] An exception was made to include 2 commercial plans with the share of spending on professional claims of approximately 11% and 98%.
[14] An exception was made for 2 Medicaid plans with the share of spending of approximately 13% and 16%.

Ultimately, the following payers were included in the analysis:

- Aetna LIC (commercial)
- Aetna Medicare (Medicare)
- CIGNA East West (commercial)
- Humana HIC (Medicare)
- Humana HMP (Medicare
- UHC of UT (commercial)
- UHC Medicare Retiree (Medicare)
- MOLINA MEDICAID (Medicaid)
- MOLINA CHP (CHIP)
- Molina Comm (commercial)
- PEHP (commercial)
- Regence (commercial)
- SelectHealth (commercial, CHIP, Medicare, Medicaid)
- Tall Tree Admin (commercial)
- UHIN EMI (commercial)
- UHIN AUCH (Medicaid)
- Univ of UT Medicaid (Medicaid)
- Medicaid (Medicaid)
- Health Choice (Medicaid)
- MotivHealth (commercial)

Of Utah's 2021 and 2022 primary care spending, the payers included represent approximately all of CHIP, 91% of commercial, 86% of Medicaid, and 86% of Medicare claims.

The following payers were excluded from the analysis:

- Aetna SRC (commercial)
- Aetna MDCR (Medicare)
- Humana HIC (commercial)
- UHC UMR (commercial)
- UHC student (commercial)
- WellPoint (commercial)
- Regence (Medicare)
- Regence BridgeSpan (commercial)
- TallTree DC (commercial)
- Univ of UT Comm (commercial)
- HMA (commercial)
- SL Behavioral Health (Medicaid)
- OPTUM TOOELE (Medicaid)